McLean County Board of Health
Regular Meeting
January 9, 2019

Members Present:	Ms. Judy Buchanan, Ms. Rose Stadel, Dr. Scott Hume, Ms. Hannah Eisner, Ms. Carla Pohl, Ms. Susan Schafer, Ms. Sonja Reece, Dr. Jim Swanson, Dr. Alan Ginzburg, Mr. Bob Kohlhase
Members Absent:	Ms. Cory Tello
Staff Present:	Ms. Camille Rodriguez, Ms. Cathy Coverston Anderson, Ms. Lisa Slater, Ms. Cathy Dreyer, Ms. Kim Anderson, Mr. Tom Anderson, Ms. Amy Hancock, Ms. Amy Brooke, Mr. Trevor Sierra, Mr. Bill Wasson, Ms. Trisha Malott
Public Present:	None

1. **Call to Order:** Meeting was called to order at 5:35 PM.

2. **Public Participation**: None

3. **Approve Minutes**:

   Motion by Kohlhase/Reece to approve the minutes of the December 12, 2018 meeting as presented.
   Motion carried.

4. **Consent Agenda**
   - **A. Bills to be Paid:**
     Motion by Ginzburg/Reece to approve the bills to be paid.
     Motion carried.

5. **Committee Reports**
   - **A. Mental Health Advisory Board:** President Buchanan (JB) noted that if Member Tello arrived later she would present information from the Mental Health Advisory Board.

B. County Board: Member Susan Schafer (SS) passed out a memo shared by County Administration in the Health Committee packet (memo attached).
Mr. Bill Wasson (BW) shared that the County is continuing to work collaboratively between departments and within the community. This year the County budgeted for two new programs that were recommended by the Behavioral Health Coordinating Council (BHCC) and approved during the budget process. The first is the FUSE (Frequent User System Engagement) project. McLean County is one of 4 counties across the country that have been working to develop a database to identify individuals that have frequent contact with hospitals, community mental health services, and/or law enforcement. Agreements are being put into place to allow the sharing of information.

The second program is the Triage Facility. This will be open for people to walk in or individuals may be transported there for Crisis evaluation. BW sees this as a supplemental to the mobile Crisis team.

Both the FUSE program and the Triage Facility will require a physical location. Available space within the Health Department, the Fairview Building, and other spaces around the County have been considered.

The County was made aware of the Center of Human Service's fiscal challenges and over the last two weeks has been working to facilitate interim solutions to address their inability to take new referrals. BW noted the significant lack of availability of psychiatrists in the community. In the last couple of years, most of the ways we have met the need for psychiatric providers has been tele-psych. The County has been actively talking to local providers to determine methods of accessing tele-psych providers. A contract has been put together with a group that is used by others in the community. It is conceivable that, on an interim basis, something like this might also be used to address the inaccessibility of referrals CHS.

BW expressed that as they look at space for the Triage Facility and the FUSE project, they are looking at different models. What makes sense from a cross utilization standpoint? Stand alone or together? What makes sense in terms of space utilization? There are broad discussions with agencies and facilities. As previously mentioned, this has included discussions with Health Department Staff. Currently there is no definitive plan in place. He asks for and appreciates the continued cooperation and assistance to meet the goals of the programs.

An additional piece of the scenario is the ability to exchange information through EMR systems. Programs attempting to divert individuals from the criminal justice system require sharing information with first responders. This allows first responders

to understand types of diversions, if any, might be appropriate. BW stated that we are sensitive that every agency has specific needs and responsibilities related to EMR.

Trisha Malott (TM) shared that they are currently in the interview process for a FUSE program manager. Ideally, this person will be hired in the next 30 days. They are also actively evaluating the individuals that may be suitable for the program. The Triage program director job description is being developed.

It is likely that the whomever provides our tele-psych access will do it for both programs. There will be one psychiatrist assigned to this program.

The issue of EMR is complicated with smaller mental health providers. They are more limited in their ability to participate. A larger portion of the work is being done with the larger providers, like hospitals, who have their own IT teams. The goal is to eventually expand the sharing of EMR data to the smaller organizations as well.

Member Robert Kohlhase (RK) asked if the physical space will be shared by FUSE and Triage.

BW explained that because there are different processes involved, they would not share a single space. However, that doesn't mean that the programs couldn't be located closely to allow for the sharing of staff.

Member Hannah Eisner (HE) asked how much pressure the initiation of the FUSE and Triage projects will take off CHS.

BW stated that it should have a complimentary, positive impact. He suggested that some of the most frequent users of CHS services could be FUSE participants. The FUSE program will recruit individuals that require intensive case management. However, there will be a limited number of people served: 10 participants per year for 5 years. The Triage program will compliment Mobile Crisis. Often those utilizing Mobile Crisis are going to the ER. Ideally, the ERs will have some relief as well. The goal is to expand services - not replace.

C. Ad Hoc Funding Committee: Ms. Camille Rodriguez (CR) reported that the committee has not convened since the last BOH meeting. Staff is working to provide the information that has been requested by the February BOH meeting.

D. Ad Hoc Contracts Committee: Ms. Cathy Dreyer (CD) reported that they have not met since the last BOH meeting. They are meeting tomorrow to review draft policy.

E. Behavioral Health Coordinating Council: Member Sonja Reece (SR) asked TM to clarify on the role of the FUSE program manager. TM clarified that the FUSE program manager links to housing but is not a housing manager. Rather, this individual will oversee the case management team. They are continuing to work to identify a place for housing. TM has had conversations with PATH regarding their Coordinated Point of Entry. There are likely individuals on the County's list that are on PATH's continuum of care list. There are supports that PATH may be able to provide through HUD funding to assist those that may be in the FUSE Program.

BW highlighted a grant that the County worked on with the Bloomington Housing Authority. It is the first time they have successfully obtained a mainstream grant vouchers. While the vouchers are not reserved for FUSE participants, people receiving these vouchers would likely also fit into the FUSE program.

BW stated that the safety of everyone involved is a consideration in the Triage Center. It is one of the reasons that proximity to the Sheriff's Department is being considered as well as Fairview where there are already two 24/7 operations. Both the Fairview location and the downtown location could meet security needs.

TM shared that they are looking at how to maintain the safety of staff as well as individuals as clients arrive via law enforcement or as walk-ins. As they proceed, they will work with law enforcement to ensure they have a guide in assessing who is appropriate for the Triage Center and who may need to go to ED.

SR asked for an update on the Practitioner Committee Meeting. A concern had been raised that APNs need more authority to allow them to order psychotropic drugs. Work is underway with ISU's Mennonite College of Nursing. TM shared that she had investigated the issue. APN's already have the authority to order psychotropic medications. They do need a collaborating physician for prescribing controlled substances. There are few additional steps for schedule two substances. For example, no more than a 30-day prescription at a time.

SR broached the topic of having someone from Court Services sit on the BHCC. BW stated that Chairman McIntyre has invited Cassy Taylor and Judge Foley to serve on the BHCC. Reciprocally, the Criminal Justice Coordinating Council (CJCC) is going to modify their bylaws so someone from BHCC can be on the CJCC.

SR shared that in 2002, 15.5% had mental health issues. Today, 26.8% of our jail population has mental health issues.

BW stated that the County has been working on this issue for about eight years. When he first had a meeting with the then sheriff and County Board Chairman to discuss the

challenges related to the detention facility, he was skeptical. He was skeptical that this was just about us being better at identifying the behavioral health issues. He has universally been told by those on the front lines that there is a significant increase in behavioral health issues. Are we better than we were 20 years ago? Yes, but there is a clear indication across the country that there is an increase in the number of people with behavioral illness.

BW thanked the BOH for their continued participation and support.

6. Director's Report

A. Center for Human Services, Psychiatry and Crisis discussion updates: CR thanked BOH members for the extra time they have given to small group sessions regarding the extension of the contracts with CHS. A list of the questions has been compiled for CHS. Additionally, MHAB decided to set a special meeting to do the same. CHS did sign the amended contracts for the 60 days. List of some of the questions:

1. Is there a wait list for those requesting psychiatric service?
2. How will CHS define when this wait list is utilized?
3. What is the total number of clients that CHS is currently able to provide psychiatric services to - accounting to the current funding being provided from all funders related to this program from sales of services?
4. Will a new client be accepted after another is closed for services?
5. What is your perception on how no new clients for psychiatric services impacts the Crisis Program?
6. How will individuals that were seen for crisis by CHS be referred to appropriate psychiatric services?
7. Is CHS currently accepting clients that are returning to psychiatric care after their case was closed?
8. What is the Center's process for discharging a client? Is it related to no shows? Is it related to refusing medication?
9. How long does it take to discharge a client before a new client is accepted?
10. How does the Center define which clients receive assistance from the funding that is allocated by this Board? CR commented that our funds are used to fund staff. It is not allocated for services. How do staff at the Center document how services provided to clients actually relate to dollars that are provided for the staff as codified within the contract that we have?
11. What are your (CHS) plans in reestablishing a no wrong door approach?
12. Is CHS willing to accept referrals from the criminal justice system even though you have said you won't take new referrals? Is there a threshold where they will reconsider this no new referrals moment?

CR asked if there were additional thoughts or concerns.

JB asked if any of the questions referenced the cost if someone could magically write a check of covering what is now not going to be done?

CR stated that it was referenced. Many of the members wanted to know where the BOH funding goes to specifically. Is it quantifiable in a service realm? CR shared that in the contract, the dollars go to a certain percentage of staff time. At the same time, CHS does provide us data on the number of individuals seen and other demographics. Our ability to turn that into a fee for service issue is challenging. Earlier this summer staff examined our ability estimate or quantify how much the services were costing. The staff had experience working in that type of environment and was unable to do it. We don't have the right information to make one equal the other.

CR shared that many members wanted to understand who the other providers of funds were to the totality of dollars needed run the program. What requirements do those partners have for how the money is used?

Member Hannah Eisner (HE) commented that we have a provider saying we can't serve several people because we don't have the money. They haven't said that they don't have the staff to do it. That is a different issue. It is key to understand the per client cost. How do you determine how much money you need unless you know the cost of providing the service per client? They must give us a number.

JB clarified that it is a matter of knowing what figure do you not have now that prompted that decision?

Member Alan Ginzburg (AG) stated that there is a huge deficit of psychiatrists in the area. There is an extremely limited number of providers for an expanding base. It may be that all the money in the world can't buy you the time that you need with a psychiatrist if you can't recruit any new psychiatrists to town. That is one part of it. The other part that is striking with CHS is that it is not just an organization to provide for the poor or uninsured. It is a hybrid. It is a private practice where the psychiatrist sees patients that are insured. Part of the practice is a funded practice. How do they determine how much of the practice is private and how much is charity care? How do they treat the patients differently?

SS stated that CHS once used a wait list. Later they stopped using it and turned people away. How many people do they turn away rather than use a wait list? In terms of finding out the dollar amounts, in the memo that was passed out (the memo from Bill Wasson, as presented to Health Committee on 12/31/18), it references that County Administration has tried to get that number and has been unable to do so.

JB asked if the problem is that they cannot buy more hours from Dr. Abelita because he doesn't have them or that they don't have the funds to purchase the hours?

SR asked if paying and non-paying patients were being turned away equally.

CR stated that generally, BOH dollars fund the public and not private. She believes the issue is related to the public side.

AG asked if the private side had expanded to the detriment of the public side.

SR asked if and when they are considering taking a new person, is it first person through the door or first person with a wallet? Is the message we aren't taking anyone new or are we aren't taking any more public pay?

SS stated that she had looked at the third quarter reports for CHS in the packet. The numbers are confusing. How many people are the staff helping? What are they billing for Medicaid?

CR noted that, at this time,she provided only an abridged version of the questions that had come from the small group discussions. There were others about innovations and sustainability. She is grateful for the robust conversation.

Following the conversation with CHS, there will be written communication to the Board of Health regarding the discussion.

HE reiterated the need for CHS to give the BOH the information in dollars and cents.

SS reminded the BOH that these are taxpayer dollars that CHS is getting from the BOH. Taxpayers want accountability for how money is spent.

7. Items for Action

A. Contracts/Grant Application List

Cathy Dreyer (CD) presented the Tobacco Free Communities grant. It is slightly less than what was received last year. The expectations for the grant are the same. Health Promotion is looking for other grants.

RK said that this contract/grant was perfect in preparing for the Contract Committee's meeting. We only need to enter into contracts that make sense. The over-riding mantra: is it worth it to accept it? This isn't just about this grant. Sometimes it costs more to follow all the rules of the grant than the grant is worth. Does this grant cover all the costs of the program? Could we cover this program without this grant by not incurring additional administrative costs? RK reiterated that there is no problem with this grant but this is the mentality for which to watch.

Motion by Kohlhase/Eisner to approve the Tobacco Free Communities contingent that staff feel the value we get is worth the administrative requirements.
Motion passed.

SS suggested that instead of sending contracts as an email that they be sent as a link in the packet. CD clarified that this document came before the link system was ready.

BOH members inquired into how many smoking violations we receive. Tom Anderson (TA) said that Environmental Health has not had a violation in at least three years. Kim Anderson (KA) shared that since she has taken over Health Promotions earlier in the summer, there has been one complaint.

8. Staff Reports

A. Maternal Child Health: KA noted that everything she has to present is in the report. She asked if the report is covering what they need to know or if BOH members had other things they would like to have addressed.

Members noted that they like how her report highlights the activities of her division. They also appreciate the succinctness.

SS noted that KA reports on the postpartum depression screening. She asked if KA knows if those referred have been seen. KA says there is no official report of if these clients are seen. However, case managers have ongoing relationships with these families. She noted that clients are referred to family physician as well as CHS.

B. Environmental Health: TA reported on the new FDA Inspection Process. Business owners are being tolerant of the process. He noted that they are asking for new forms. We do not have those on the website yet. As a result, we are not counting them in deficit for not having them. Staff are carrying hard copies of the forms and providing them that way. The forms are medical reporting forms that come into play when an individual is going through the hiring process and if they become ill while working at the establishment.

RK commended TA on the analysis of the new forms.

TA will provide an analysis of the length of inspection times compared to the last 3-5 years. Classes regarding the regulations are filling up.

Members asked why complaints on food establishments and nuisances have increased.

TA stated that the new trend in food establishment is an open floor plan. As a result, customers may see how their food is handled. The department is obligated to investigate every complaint. Nuisance complaints are increasing across the country. These are often bed bug complaints.

C. **Administration:** Amy Hancock (AH) directed members to the quarterly statistics.

HE would like clarification on the total served and new served and duplicated versus unduplicated.

AH clarified that all clients are new clients at the beginning of the year. She will clarify with agencies regarding their definitions and the correct way to report.

SR asked, in looking at the numbers, when Ms. Hancock would be concerned.

AH shared that she would be concerned if they failed to meet an agreed upon number. Also, she would be concerned if their expenses were more than their revenue.

HE asked for clarification on the Labyrinth numbers.

AH stated that there are only 8 residents that can live there at any one time. However, they serve more than that through groups and classes. She will check for errors

D. Community Health Services: Cathy Coverston Anderson (CA) shared that the dental program will begin having evening hours the 3rd Monday of the month.

CA shared that IDPH has put out a press releases on the Hepatitis A outbreak. There are 75 confirmed cases in IL. Not all are related to the outbreak. There are three confirmed cases in McLean County. We have received free vaccine from CDC for those at a high risk: homeless, those engaged in man to man sexual encounters, detention facilities, and those that work with those individuals.

CA is also working on the Community Needs Assessment

9. Other

A. Motion by Schafer/Reece to go into Closed Session pursuant to section 2(c)(1) of the Open Meetings Action (5ILCS 120/2(c)(1) to discuss the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity.
Motion carried

B. Resume Open Session

Motion by Kohlhase/Pohl to resume open session.
Motion carried.

C. Action Item

Motion by Kohlhase/Pohl for the Board to provide a $150 vehicle allowance to Camille Rodriguez as Health Department Administrator for 2019 to be used for travel and parking.
Motion carried.

10. Adjourn

Motion by Stadel/Hume to adjourn.
Motion carried.

McLean County

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TO: Chairman and Members, Health Committee

FROM: Bill Wasson, County Administrator
Trisha Malott, Behavioral Health Coordinating Council (BHCC) Supervisor

DATE: December 26, 2018

RE: Psychiatric Service Referrals -Interim Steps

As the Committee is aware, on the afternoon of December 3rd, before the regularly scheduled Health Committee Meeting, the Center for Human Services(CHS) made an announcement that they are unable to accept new referrals for Psychiatric treatment. County staff were notified the previous week that CHS was encountering fiscal challenges, which might require them to take such an action, but that they were still exploring funding alternatives. County staff asked what level of funding would be required to address the fiscal issues and CHS was unable to provide for such, acknowledging the loss of recent United Way funding and changes to Illinois Department of Human Services Funding over the last several years. County staff requested additional information concerning budgetary and actual staffing utilization program detail to assist in understanding the financial reports provided by CHS to the County and how the County might appropriately assist with these issues.

Psychiatric referrals can come from a number of sources including the Mobile Crisis team, hospital emergency rooms, the jail & courts and primary care physicians. The County currently provides supplemental funding through the Board of Health for both the CHS psychiatric service programs and Mobile Crisis programs. Upon receipt of the notice from CHS that they were unable to accept new referrals, the Staff of the County Administrator's Office initiated outreach, working with county agencies, to determine if there was any capacity for additional psychiatric capacity within the Community. This followed conversations the County had with providers and hospitals during the budget preparation process for the BHCC Frequent User Engagement Systems (FUSE) program where it was delineated that no providers, including CHS had the capacity to increase psychiatric load, even with compensation.

Acknowledging the impact that CHS no longer accepting referrals creates within the community and for other providers, County staff engaged over the course of the first week after the notice to identify providers of psychiatric services delivered by secure video-conference technology. With the national limitations on available psychiatric services, the necessary and approved utilization of telemedicine for such services is used by the majority of providers in the community including Chestnut Health Systems, the Center for Youth and Family Solutions, County Detention Facilities and BroMenn Advocate. Staff were successful in identifying several provider groups who had the capacity and ability to enter into interim contracts for service to allow the County to assist in providing psychiatric assessment to

individuals requiring assistance while longer-term strategies to deliver services are reviewed. The staff advised the County Board Executive Committee on December 11th that they had been successful in getting commitments for new problem solving courts clients to be seen by Chestnut, and that they were beginning negotiations with a medical group to provide interim psychiatric services that could provide an opportunity to help lessen the impact of CHS's issues and allow for opportunity to develop longer term plans in concert with partner agencies and county departments. This capacity to provide interim psychiatric services is provided by the programs budgeted under BHCC for FY2019, including the FUSE and Triage programs. On Friday the 14th, Administration staff reported to the BHCC that they were working to attempt to reduce the impact created by CSH's financial difficulties and provided updates regarding BHCC FUSE and Triage programs recommended by BHCC in September and approved by the County Board in November.

County Administration and States Attorney's Office staff were successful in working to negotiate a contract with the preferred group between Tuesday, December 11th and Monday, December 17th. County staff received final approval of changes from the Group's law firm at 4:33 PM on the 17th and sent out information to the County Board upon completion. The preparation and development of an alternative process for referrals is not by any means the end of the interim process, nor a permanent solution. We continue to have conversations with our county agencies and community partners about how to best address the short and long-term challenges we are encountering.

With respect to Health Committee oversight, we will be asking the Board of Health and the Health Department's cooperation as we determine the best utilization of county space to provide a wider variety of behavioral health services than was previously envisioned in the unoccupied space in 200 West Front for the FUSE program. This may include, especially in the short-term, sharing space or modifying the specific space dependent upon current utilization and space needs for all programs by both BHCC or the Health Department in the 200 W. Front Building. Additionally, Information Services has been in discussion with the Health Department, Nursing Home and Detention Medical staff concerning improvements desired in Electronic Medical Records (EMR) systems, utilization of current EMR systems and ultimately working toward a universal EMR system that will allow for improved information sharing between county agencies and appropriate levels of case management information sharing with our community providers.

Long term solutions to the psychiatric service shortage which is plaguing virtually every community in the country will require that we work not only effectively interdepartmentally, but also by developing formal partnerships with our community providers to best utilize finite funding and resources. The ability to provide sufficient services will require that we not only develop unique and new methods of delivery and recruitment, but that we also are responding to the everchanging landscape of healthcare and behavioral health, with consideration to changing revenue recovery and funding priorities.